SELECT JOINT COMMITTEE ON MEDICAID OVERSIGHT

Legislative Services Agency
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MEETING MINUTES[1]

Meeting Date:	October 5, 1999
Meeting Time:	1:00 P.M.
Meeting Place:	State House, Room 404 200 W. Washington St.
Meeting City:	Indianapolis, Indiana
Meeting Number:	3

Members Present: Rep. William Crawford, Chairperson; Rep. Charlie Brown; Rep. Vaneta Becker; Sen. Patricia Miller; Sen. Robert Meeks; Sen. Joseph Zakas; Sen. Rose Antich.

Members Absent: Rep. William Bailey; Rep. Ralph Ayres; Rep. David Frizzell; Sen. Samuel Smith, Jr.; Sen. Vi Simpson.

Rep. Crawford called the meeting to order at 1:05 p.m. Rep. Crawford reported to the Committee that the Legislative Council had denied the Committee's request to meet after October 31, so the Committee will hold one more meeting this year. Rep. Crawford reminded Committee members that although the Committee is not required to make any formal findings, any legislation or other recommendations the Committee might wish to make must be approved by a majority of the Committee members at a public meeting. Sen. Miller suggested that the Committee prepare a bill establishing the Committee as a statutory committee. Rep. Crawford directed LSA staff to draft this bill for the Committee's consideration at the next meeting.

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[1] Exhibits and other materials referenced in these minutes can be inspected and copied in the Legislative Information Center in Room 230 of the State House in Indianapolis, Indiana. Requests for copies may be mailed to the Legislative Information Center, Legislative Services Agency, 200 West Washington Street, Indianapolis, IN 46204-2789. A fee of $0.15 per page and mailing costs will be charged for copies. These minutes are also available on the Internet at the General Assembly homepage. The URL address of the General Assembly homepage is http://www.ai.org/legislative/. No fee is charged for viewing, downloading, or printing minutes from the Internet.

Electronic Data Systems (EDS) Processing Update

In response to questions raised by Committee members at previous meetings, Mary Simpson from EDS presented Committee members with a handout detailing the following: claims processing statistics, suspended claims statistics, customer assistance calls statistics, and Indiana AIM Medicaid dental services delivery analysis. (See Exhibit 1.) Ms. Simpson requested an opportunity to present the results of a provider survey to the Committee at a future meeting. Rep. Crawford announced that the Committee would hear testimony on this survey at its next meeting.

Provider Reimbursement under Medicaid Managed Care and the Children's Health Insurance Program (CHIP)

Rep. David Yount, District 59, stated that limited access to primary care providers for Medicaid patients, particularly children, is rapidly reaching a crisis point. Rep. Yount introduced several speakers who are Medicaid participating providers and distributed a handout to Committee members containing brief credentials of the speakers and various materials relating to Medicaid provider reimbursement. (See Exhibit 2.)

David Larson, M.D., Columbus Pediatrics, Columbus, Indiana, told the Committee that he has been a practicing pediatrician in Columbus since 1974 and has served Medicaid patients as long as he has been in practice. Dr. Larson stated that access to medical care for Medicaid and CHIP patients is being severely restricted by a lack of physician providers and that the lack of providers is due to the unattractiveness of the Medicaid program, particularly the reimbursement rates. Dr. Larson observed that several changes in the practice of medicine have combined with the low reimbursement rates paid by Medicaid to make participating in Medicaid unappealing to medical providers, including increases in overhead costs, other providers with heavy Medicaid patient loads retiring, other reimbursement (i.e., private pay insurance) tightening up, and an increase in the number of persons eligible for Medicaid or CHIP.

In response to a question from Rep. Brown, Dr. Larson stated that overhead costs have increased due to "people costs" (e.g., processing of claims, collections, dealing with insurance) as well as increases in the cost of supplies and immunizations. Dr. Larson noted that for his practice, the charge for an average office visit has increased from $36 in 1994 to $44 in 1999. Dr. Larson noted that the last time Medicaid reimbursement rates were adjusted was in 1994, when the rates were decreased. Dr. Larson observed that the current reimbursement rates for Medicaid only cover about 60% of the cost of the service, which does not even cover a provider's overhead costs for providing the service. Dr. Larson commented that the current system is comparable to requiring participating physicians to pay for serving Medicaid and CHIP patients.

In response to questions from Sen. Miller and Rep. Brown, Dr. Larson stated that his office staff could probably be reduced by two persons if the Medicaid administrative requirements were reduced, but that any savings achieved by reducing overhead in this manner would still not be enough for providers to meet their costs.

Scott Taylor, M.D., Northside Pediatrics, Columbus, Indiana, reported to the Committee that one of the biggest drawbacks to the Medicaid and CHIP programs is the "hassle factor" for doctors and their staff as well as patients. Dr. Taylor declared that while the auto assignment feature of Medicaid was intended to benefit providers and Medicaid recipients by automatically assigning patients to providers who were taking new Medicaid patients, the system is actually causing problems. Dr. Taylor related a situation that occurred in his office where a person who is a relative of one of his established patients

arrived for an appointment but, upon scanning the person's Medicaid card, it was discovered that the person had been assigned another doctor as the person's primary care provider. Dr. Taylor explained that in such a situation, he or his staff must contact the other physician to get approval to see the patient, all while the patient is waiting in the office. Dr. Taylor asserted that this delay not only requires time and effort from his office staff, but it harms the dignity of the patient, and often affects other patients by delaying their appointments. Dr. Taylor also noted that his office must appeal to the Office of Medicaid Policy and Planning (OMPP) to approve a visit of an established patient who has recently enrolled in Medicaid because the computer system recognizes his office's Medicaid panel as full.

Dr. Taylor asserted that many patients don't seem to understand the system and that the lack of personal contact in the system adds to the confusion. Dr. Taylor stated that the problems with the Medicaid system make it very difficult to encourage other providers to participate or to encourage participating providers to increase the size of their Medicaid panels. Dr. Taylor noted that in Bartholomew County, there are 200 Medicaid or CHIP enrolled children waiting for primary medical providers.

In response to questions from Sen. Meeks, Dr. Taylor informed the Committee that the Medicaid reimbursement rate would need to be equal to 70% of a provider's cost in order for the provider to break even (i.e, an increase of approximately 15% over the current reimbursement rates). Responding to a question from Sen. Miller, Dr. Taylor said that his practice is currently not taking any new patients, whether Medicaid or private insurance. Answering a question from Rep. Brown, Dr. Taylor told the Committee that of 22 primary care providers in Bartholomew County, 14 participate in Medicaid/CHIP.

William A. Engle, M.D., Assistant Professor of Pediatrics, Indiana University School of Medicine and James Whitcomb Riley Hospital for Children, observed that the issue of limited access for Medicaid and CHIP patients due to low reimbursement of providers was predicted to the Governor's CHIP panel. Dr. Engle noted that Indiana's Medicaid reimbursement rates are lower than both the regional and national Medicaid reimbursement, as well as Medicare reimbursement. Dr. Engle reported that not having access to a primary care provider may force some Medicaid patients to seek routine treatment at the emergency room, or delay treatment until the situation requires costly emergency room treatment. In addition, Dr. Engle stated that lack of access to a pediatrician may cause some children to be seen by providers who are not well trained in treating children.

Dr. Engle commented that studies have shown that increasing access to primary care providers decreases Medicaid costs. Dr. Engle noted that the number of physicians in the audience who had taken time out of their practices to attend the Committee's meeting is evidence of the importance of the issues of provider reimbursement and access to care. Dr. Engle asserted four reasons for increasing the reimbursement rates paid to providers participating in Medicaid: better medical care (i.e., prevention); decreased costs overall; allow providers, especially in rural and inner city areas, to serve Medicaid/CHIP patients without jeopardizing their practice; and fairness, because the rates have not been increased since 1994. (See Exhibit 3 for a written copy of Dr. Engle's testimony.)

Robert Hannemann, M.D., Arnett Clinic, Lafayette, Indiana, noted that lack of access to pediatric services is not unique to Indiana, but is being experienced in other states as well. Dr. Hannemann reported that most Indiana physicians who treat children accept Medicaid patients but hesitate to accept more due to reimbursement rates being below actual costs. Dr. Hannemann related several situations he had encountered where confusion over assignment, full Medicaid panels, or lack of participating providers in a particular area had

resulted in a delay in Medicaid patients receiving care or utilization of emergency room services. (See Exhibit 4 for a written copy of Dr. Hannemann's testimony.)

Kathy Gifford, Assistant Secretary, OMPP, responding to questions raised by Rep. Brown and Sen. Antich during Dr. Taylor's testimony, stated that there are some problems with the auto-assignment procedure, particularly in Bartholomew County, and that OMPP is working on addressing the problems. Ms. Gifford observed that most of the problems occur when the computer shows a particular provider's Medicaid panel as full. Ms. Gifford explained a person who has an existing relationship with a particular provider may be automatically assigned to a different provider if the provider's panel is full, but that OMPP is working on a solution to this problem. Ms. Gifford declared that OMPP did not provide any more assistance in outreach to Bartholomew County than to any other county, but that the outreach efforts in Bartholomew County had been particularly successful and the large number of new enrollees was contributing to some of the problems. Ms. Gifford remarked that OMPP is currently analyzing data to determine if any other counties are having trouble similar to that in Bartholomew County. Ms. Gifford stated that OMPP is committed to working on whatever problems arise, including those that may be specific to a particular county. She also distributed to Committee members a letter reflecting efforts by OMPP to address various issues in Bartholomew County. (See Exhibit 5.)

Replying to a question from Sen. Zakas, Ms. Gifford stated that OMPP does not need additional staff at this time. Sen. Meeks commented that the testimony the Committee received from the physician providers sounds much like testimony received from dental providers a few years ago and that OMPP should try to avoid such issues becoming a trend in Medicaid. Rep. Crawford asserted that something needs to be done now to address the problems due to the recent Medicaid expansion and the more than 100,000 persons who will now be eligible.

Ms. Gifford distributed two handouts that compare fee-for-service Medicaid payments in Indiana to payments in selected other states and to Medicare and private fees. (See Exhibits 6 and 7.) Ms. Gifford explained that the reduction in Medicaid reimbursement rates that occurred in 1994 was a result of a policy decision that Indiana should not continue paying more for the same services than other states were paying. Ms. Gifford stated that Indiana's reimbursement rates are now more in line with other states' rates than before 1994. Ms. Gifford reported that the legal standard is that OMPP must pay what is necessary to have enough providers to provide the necessary services. Responding to questions from Sen. Miller, Ms. Gifford stated that OMPP's policy is now focused on serving people, not avoiding paying more than other states. Ms. Gifford asserted that OMPP wants to cover providers' reasonable necessary costs of providing services. Ms. Gifford stated that one impediment to increasing reimbursement rates for services to children in the new CHIP program (i.e., Phase 2) is that the budget appropriation for that phase of the program was based on an underestimation of new eligibles.

Rep. Becker commented that solutions to the problems with Medicaid can't wait -- the state has taken on the responsibility of providing health care services to an expanded population and the state now needs to pay for it. Rep. Brown requested that OMPP provide the Committee with projections of what it would cost to get all 22 Bartholomew County providers to participate in Medicaid and CHIP and for those providers to both break even and make a profit. Ms. Gifford noted that every doctor's break-even point would be somewhat different and that merely raising the reimbursement rates might not be enough to encourage all providers to participate, but that the "hassle factor" might keep some providers from participating. Rep. Crawford directed OMPP to provide the Committee with some information on the state-wide cost and impact of increasing provider reimbursement rates. Rep. Crawford asserted that history shows that past state public policy had created

the problem with dental provider participation and the state should seek to avoid repeating that problem with medical providers.

Responding to questions from Sen. Miller and Sen. Antich, Ms. Gifford reported that OMPP has approximately 70 employees, while EDS has about 300. Ms. Gifford also noted that while OMPP is allowed to use up to 10% (or $10 million) for administration, only about 3% is actually used, including the contract with EDS. Ms. Gifford declared that this is much less than the percentage of total program costs spent for the administration of many other state Medicaid programs and most private insurance companies. Sen. Antich expressed interest in seeing a breakdown of how the CHIP money is spent, including a specific breakdown of administrative expense categories. Rep. Becker reminded the Committee that the money that OMPP uses for administration does not just go to pay the salaries of OMPP employees, but also covers state-wide efforts to implement CHIP.

In answer to questions from Sen. Antich, Ms. Gifford stated that Managed Health Services (MHS) is expected to negotiate to provide services in the second CHIP phase. Ms. Gifford noted that, in accordance with the existing "any willing provider" law, MHS had offered to contract with Walgreen's pharmacies under the same terms as its contract with CVS pharmacies, but that Walgreen's had chosen not to accept the terms. Ms. Gifford remarked that her understanding is that MHS currently has a three-year exclusive contract with CVS. Rep. Brown requested that Ms. Gifford provide the Committee with information regarding the costs paid for transportation for Medicaid members to get their prescriptions filled at an in-plan pharmacy located farther away from the members' homes than a pharmacy not in the plan.

Thomas Felger, M.D., Chairman, Commission on Health Care Services, Indiana Academy of Family Physicians, informed the Committee that the position of the Indiana Academy of Family Physicians is that Medicaid reimbursement to providers should be equal to 100 to 125% of Medicare allowed charges. Responding to a question from Rep. Brown, Dr. Felger stated that he was not aware of any other states that currently tie Medicaid reimbursement rates to Medicare rates. Dr. Felger noted that although the automatic assignment process has improved, the "hassle factor" referred to by previous witnesses exists throughout the state. Dr. Felger cautioned that a lack of access to primary care providers can lead to increased Medicaid costs due to greater use of emergency room services. (See Exhibit 8 for a written copy of Dr. Felger's testimony.)

Rep. Crawford distributed to Committee members a memorandum from the Indiana Chapter of the American College of Emergency Physicians regarding emergency medicine reimbursement for the risk-based managed care Medicaid program. (See Exhibit 9.) Rep. Crawford directed Kathy Gifford of OMPP to respond to the issues raised in this memorandum at the Committee's next meeting.

Use of Federal Funding under Hoosier Healthwise

Lauren Polite, Legislative Liaison, Family and Social Services Administration (FSSA), distributed a handout addressing Indiana's use of the federal CHIP grant and federal Medicaid "de-linking" funds. (See Exhibit 10.) Ms. Polite explained that Indiana has three years in which to spend the federal CHIP money (i.e., the year of allocation plus two years). In response to a question from Sen. Meeks, Ms. Gifford of OMPP said that any money allocated for administrative expenses but not spent would be spent on providing services to Medicaid members. Responding to questions from Sen. Miller, Ms. Polite noted that Indiana has approximately $3½ million remaining from the 1999 allocation. Ms. Polite stated that this money is held at the federal level and that FSSA expects to spend this money in state fiscal year 2000. Ms. Polite also reported that to date, the state share of

CHIP money has not been set aside in a separate account, but that $17 million and $25 million would be set aside for state fiscal years 2000 and 2001, respectively. Responding to a question from Sen. Meeks, Ms. Polite explained that the federal money is pulled down through claims for reimbursement once state dollars have been spent.

Regarding the use of federal funds to de-link Medicaid from cash assistance, Ms. Polite declared that Indiana has been touted as a success story. Ms. Polite stated that Indiana, like many other states, had not spent all the federal funds allocated for de-linking activities. Rep. Crawford asked Ms. Polite to provide the Committee with some data regarding FSSA's ability to track persons who are no longer eligible for Temporary Assistance to Needy Families (TANF) but who are still eligible for Medicaid to determine if they are in fact still enrolled in Medicaid.

In response to a question from Rep. Brown regarding how many children have been enrolled at emergency rooms, Ms. Polite stated that the enrollment data only indicates if a child was enrolled at a hospital enrollment center, but does not specify the department of the hospital the child was enrolled through, or even if the child was at the hospital to receive medical care. Rep. Brown asked Ms. Polite to provide the Committee with enrollment data, broken down by the type of enrollment center where enrollment was completed.

Medicaid Institution for Mental Disease (IMD) Exclusion

Sen. Meeks remarked that several people had brought to his attention an issue regarding the prohibition against Medicaid reimbursement for services rendered in an IMD, and introduced two persons to speak on the issue.

John V. Barnett, Jr., Charter Behavioral Health Systems, urged the Committee to enact legislation to allow Medicaid reimbursement for services performed in an IMD.

Robin Huffman, Executive Director of Legislative Affairs, Charter Behavioral Health Systems, distributed a handout to Committee members containing background information on the Medicaid IMD exclusion. (See Exhibit 11.) Ms. Huffman explained that Medicaid prohibits federal medical assistance payments for patients between the ages of 21 and 64 residing in an IMD, but that this exclusion does not apply to persons under 21 who reside in IMDs or to psychiatric units in general hospitals. Ms. Huffman remarked that this exclusion often has the effect of limiting access to care, as many hospital psychiatric wards or Medicaid beds are at capacity. Ms. Huffman also noted that care provided in a general hospital's psychiatric ward is often much more expensive than care provided in an IMD.

Ms. Huffman reported that many states have sought a §1115 demonstration waiver from the Health Care Financing Administration (HCFA) to be able to provide Medicaid reimbursement for services in IMDs. Ms. Huffman distributed to Committee members a copy of a document showing states that currently have §1115 waivers. (See Exhibit 12.) Ms. Huffman asserted that Indiana's obtaining a waiver to reimburse for IMD services could result in cost savings due to increased competition, increased choice for patients, improved access, and early intervention to prevent later, more expensive treatment. (See Exhibit 13 for a written copy of Ms. Huffman's testimony.)

Responding to a question from Rep. Crawford, Ms. Gifford of OMPP noted that Indiana has no experience with §1115 waivers, but that the Hoosier Healthwise managed care project is conducted under a §1915(b) freedom of choice waiver, with mental health services specifically excluded from the scope of the waiver. Answering questions from

Sen. Meeks, Ms. Gifford stated that mental health services were specifically excluded from the Hoosier Healthwise managed care project because the provision of these services was to be addressed through the Hoosier Assurance Plan of the Division of Mental Health. Sen. Meeks requested that Ms. Gifford provide the Committee with data regarding the number of persons served in hospital psychiatric units, the Medicaid dollars spent for providing those services, and possible savings that could be achieved through use of a waiver regarding IMDs. Ms. Gifford cautioned Committee members that much consideration would be required before determining whether Indiana should establish a policy of handling mental health services through managed care, particularly the impact that managed care in this area might have on community mental health centers across the state.

Robert C. Hails, Chief Executive Officer, Charter Beacon Behavioral Health Centers, Fort Wayne, Indiana, remarked that mental health problems do not only affect the individual afflicted, but the family members of the individual as well. In response to a concern raised by Sen. Miller, Mr. Hails stated that before a child can be admitted to a Charter facility, a physician must diagnose the child as needing the type of treatment provided at the facility.

Medicaid Enrollment Brokers and the Hoosier Healthwise Member Survey

Carl Hendrickson, Market Measurement, gave Committee members a handout detailing results of the 1998 Hoosier Healthwise member satisfaction survey. (See Exhibit 14.) Mr. Hendrickson stated that overall, the Hoosier Healthwise program was doing well. Specifically, Mr. Hendrickson noted that members' overall satisfaction with the program and providers was good and that there was an improvement of members' health status. Rep. Brown asked Mr. Hendrickson to provide the Committee with a copy of the survey instrument used for the study. Mr. Hendrickson also told the Committee that a 1999 survey of participating medical providers showed that losing patients inappropriately through the auto assignment process was cited as a major problem by 17% of respondents, down from 35% in a 1998 survey. In answer to questions from Rep. Crawford regarding the sample used for the survey, Mr. Hendrickson commented that the accuracy of a survey depends upon the sample size used, not the total population, and that three times the number of samples needed for statistical accuracy were taken for the Hoosier Healthwise member survey.

Sharon Steadman, Director, Managed Care Program, OMPP, informed the Committee that OMPP is taking the results of the member survey very seriously and is trying to improve access, quality of care, and cost effectiveness wherever possible. For example, Ms. Steadman stated that as a result of the survey, OMPP has started distributing additional information on dental providers and benefits. In response to questions from Rep. Crawford, Ms. Steadman noted that there is a toll-free telephone number for Hoosier Healthwise members to call regarding any problem. Ms. Steadman observed that the help line receives approximately 25,000 calls per month, with an average wait of 44 seconds per call and an average call time of three minutes. Responding to a question from Rep. Brown, Ms. Gifford of OMPP explained that Hoosier Healthwise includes both traditional Medicaid for children and families, the Medicaid expansion under Phase 1 of CHIP, and the upcoming CHIP Phase 2. Ms. Steadman gave Committee members a handout showing an overview of Hoosier Healthwise. (See Exhibit 15.)

Lynn Irelan, Executive Director, Lifemark Corporation, Indiana, distributed to Committee members an overview of Hoosier Healthwise enrollment brokers. (See Exhibit 16.) Ms. Irelan explained that enrollment brokers serve to help Medicaid members understand and use the Medicaid process to obtain the services they need and to try to solve any problems that arise, or at least refer the member to someone who can help resolve the problem. In

response to questions from Rep. Crawford regarding the materials that Lifemark distributes to Medicaid members, Ms. Irelan noted that Lifemark's contract with OMPP requires that member materials be at a fifth grade reading level. Ms. Irelan also reported that Lifemark does substantial field testing of new member materials before using them. Ms. Irelan gave Committee members copies of several pamphlets that are given to members of the Primary Care Case Management (PCCM or "Prime Step") program of Hoosier Healthwise. (See Exhibit 17.)

In answer to a question from Rep. Crawford, Ms. Irelan stated that Lifemark's corporation headquarters are in Phoenix, Arizona, but the company has satellite offices in six states, including Indiana. Rep. Crawford remarked that the owl, the mascot used for the Hoosier Healthwise materials, is a symbol of death for Native Americans and, possibly, Hispanics. Ms. Polite of FSSA stated that FSSA has changed the materials for the Native American community and would look into potential problems with the materials with the Hispanic community.

Rep. Crawford inquired as to the length of Lifemark's contract and whether there are scheduled reviews by OMPP. Ms. Irelan reported that Lifemark's base contract with OMPP, which expires at the end of this year, is for two years with two one-year extension options. Ms. Steadman of OMPP observed that the oversight of Lifemark is conducted on an on-going basis as any problems are brought to OMPP's attention. In response to a question from Rep. Crawford regarding any complaints made about the benefit advocates, Ms. Gifford of OMPP stated that the office does receive some complaints about the advocates, including some complaints from the county Offices of Family and Children, but not many.

Adjournment

There being no further business to come before the Committee, Rep. Crawford adjourned the meeting at approximately 4:25 p.m.

Next Meeting

The next meeting of the Committee will be Friday October 22, 1999, at 10:30 a.m. in Room 404 of the State House. (This will be the Committee's final meeting this year.)

(Indications of meeting date, time, and room location in these minutes are subject to change. Please refer to the most recent Calendar of Meetings distributed by the Legislative Information Center for official meeting information.)